Details of Monitoring Activities
For the Dane County SSI Managed Care Program
November 2005

Applicable Program	Personnel Responsible	Description of Activity	Freq. of Use	How it yields info. About Monitored Area
B. Accreditation for Participation (Preparticipation Certification Review) for Dane Co. SSI MC Program.	Jody Mender, DHCF, Peg Algar, DHCF, Randy Zirk, DHCF, Joyce Allen, DDES	Pending approval of OCI Licensure, Community Living Alliance (CLA) is progressing toward a January 1, 2006 implementation of the Dane County SSI Managed Care Program. In preparation for program implementation, the Division of Health Care Financing (DHCF) will conduct an on-site readiness review. CLA will have their contract administrator and internal advocate available during the site visit to answer questions. DHCF met with a representative from CLA to go over the areas that will be addressed by the readiness review. An agenda for the readiness review will be forwarded to CLA one week before the site visit.	One initial review prior to implementation of the program with potential follow up visits based on initial findings.	The following areas will be reviewed during the site visit: 1. Access 1a. Provider Contracts 1b. Group Contracts-Independent Physician Associations (IPAs) 1c. Administrative Service Agreements (ASAs) 1d. Provider Network Listing 2. MOUs with County 51.42 Agencies or other contracted agencies. 3. Quality Improvement. 4. Recipient Grievance Policy and Procedures 5. Provider Appeal Process 6. Advocate Work Plan and Job Description 7. Enrollee Handbook 8. Reporting Requirements 9. Encounter Data 10. Computer and Data Processing System 11. Translation Policies Procedures All of the above areas will be reviewed to assess whether the MCO meets specifications outlined in the Medicaid contract. Three possible courses of action will be taken based on site visit results: 1. If there are issues of enrollee access or quality of care that do not appear to be able to be solved within a reasonable amount of time, the contract will not be granted. 2. If there are issues that need to be resolved but appear to be part of the learning curve of a new MCO, a delay in contract approval will be made until requirements are met. 3. A provisional contract will be signed with

				requirements in place for the MCO to meet contract criteria within a specified amount of time.
C. Consumer Self-Report data (SSI-CAHPS) for Dane Co. SSI MC Program.	Angie Dombrowicki, DHCF, APS Inc.	The standard adult FFS CAHPS 2.0 questionnaire has been modified to focus on items pertinent to the SSI population. A random sample will be drawn from Medicaid FFS eligibility files and stratified as follows: (1) SSI adults in Dane County with indications of severe persistent mental illness (SPMI), and (2) other adults with disabilities in Dane County. The survey will consist of a mailed questionnaire, with one follow-up mailing, and then telephone interviewing for those who have not responded by mail. The survey will be available in English, Spanish, Hmong and Russian.	The baseline FFS CAHPS will be administered in early 2006. DHCF is currently exploring the possibility of pilot testing the CAHPS module for persons with mobility impairments as part of this survey. Future plans are to repeat an SSI-CAHPS every other year.	The data will be analyzed using the standard CAHPS analytical software to produce the Core CAHPS satisfaction measures. The full set of SSI-CAHPS questionnaire item response profiles will also be included in the final report, as an attachment. The results of the pre-implementation SSI-CAHPS Survey will be used to provide FFS baseline survey data for comparison of consumer satisfaction before and after the SSI managed care implementation.
D. Data Analysis (Grievances and appeals data) for Dane Co. SSI MC Program.	Peg Algar, DHCF	The MCO reports on the formal and informal grievances it receives. The categories reported are: 1.) Formal Grievances a. Subtotal Program Administration b. Subtotal Benefit Denials/Reductions 2.) Informal Grievances a. Subtotal Program Administration *Access Problems *Billing Issues *Quality of Care *Denial of Service (May be split out by type.) *Other (specify) b. Subtotal Benefits Denial/Reductions These numbers are compared from month to month and the Department investigates if there is a significant increase in the number of grievances in any category. Grievances submitted to the Department are reviewed and adjudicated by qualified Department personnel. The specific	Quarterly	Trends in grievances may provide important information about access and comprehensiveness of care provided by the MCO.

		details of the grievances are summarized and reported on a quarterly basis. If analysis shows any significant changes in numbers or trends in denials of a particular type of service, there will be follow up by the Bureau of Managed Health Care Programs and/or the contracted external advocate.		
E. Enrollee Hotlines operated by the State for the Dane Co. SSI MC Program.	Automated Health Systems Inc., Ombudsmen Program	The State receives weekly call reports from the Enrollment Specialist. The hotline workers keep statistics on categories of calls and will be able to distinguish which calls are related to the Dane SSI MC Program. All of the calls are entered into a contact database, which contains a record of the content of all calls. In addition, the State's Fiscal Agent employs one full time ombudsman to receive calls from enrollees who need assistance or who have complaints about their MCO. Ombuds assist the enrollee's in getting needed services, and they help with grievances when necessary.	Weekly	State staff reviews call statistics on a weekly basis. If any of the statistics are unsatisfactory, an audit of the MCO is done and if necessary, corrective action is taken based on procedure outlined in the Medicaid contract.
G. Geographic mapping of provider network for Dane Co. SSI MC Program.	Bureau of Information Systems and DHCF	A map showing the location and distance of providers from the zip code area of enrollees is created to assess whether the provider network is adequate for the enrollment.	Done during the initial readiness review and thereafter during the contract renewal periods and when there are significant changes in the network, or as a result of changes, additions, and/or deletions of providers in the network.	The map is used to analyze the adequacy of the providers in the network to meet access and capacity guidelines outlined in the Medicaid contract.
H. Independent Assessment of program impact, access, quality, and cost-effectiveness for Dane Co. SSI MC Program.	TBA	The department will arrange for an independent evaluation of Dane Co. SSI Managed Care Program which will include the following components: (i) The cost-effectiveness of the project; (ii) The effect of the project on the accessibility and quality of services; (iii) The anticipated impact of the project on the State's Medicaid program.	This is required for 1915(b) Waiver Programs, and thus may not be required for the Dane SSI MC Program, as the waiver application will be withdrawn.	(i) Cost Effectiveness of the Waiver: The total costs of the waiver, including program benefits and administrative costs, must not be greater than the cost of providing like services without a waiver. The IA should compare the cost of the waiver program to the estimated cost of the same services to an actuarially equivalent population without the waiver. (ii) Quality of Waiver Services: The quality of services under a 1915(b) waiver program may not be less than the quality of services prior to or without the waiver. The IA should evaluate the impact of the quality of services provided to beneficiaries

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				(iii) under the waiver and define measures to improve and ensure quality of care. Beneficiary Access to Services Under the Waiver: A waiver program under 1915(b) may not substantially impair a beneficiary's access to services as compared to accessibility of services prior to or without the waiver. The IA should evaluate or measure the availability of services under the waiver and compare it to the level of waiver services that existed prior to the waiver.
I. Measurement of any disparities by racial or ethnic groups for Dane Co. SSI MC Program.	Peg Algar, DHCF	The MCO is required to address the special health needs of enrollees such as those who are low income or members of a minority population group needing specific culturally competent services, and to incorporate in its policies, administration, and service practice the values of: a. Recognizing members' beliefs. b. Addressing cultural differences in a competent manner. c. Fostering in staff/providers attitudes and interpersonal communication styles, which respect enrollees' cultural backgrounds.	As needed.	The MCO will be required to have specific policy statements on these topics and communicate them to subcontractors. The MCO will be required to encourage and foster cultural competency among providers and when appropriate, permit enrollees to choose providers from among the MCO's network based on cultural preference. Enrollees may submit grievances to the MCO and/or the Department related to inability to obtain culturally appropriate care, and the Department may, pursuant to such grievance, permit an enrollee to disenroll and enroll.
J. Network adequacy assurance for Dane Co. SSI MC Program.	Jodie Mender, DHCF, Peg Algar, DHCF, Joyce Allen, DDES.	In order to evaluate the adequacy of the MCO's provider network, all MCOs must supply the Department with their provider network details. The Department reviews the information submitted to determine whether the MCO has the ability to provide full access to Medicaid covered services. MCO must provide documentation and assurance of the network adequacy criteria as required by the Department in the Medicaid contract. They are required to report any changes in their network to DHCF.	Network adequacy will be assessed during the initial Readiness Review and during any contract ongoing renewal period(s). In addition, the MCO must update the documentation and assurance to the Department with respect to network adequacy whenever there has been a significant change, as defined by the Department, in the MCO's operations that would affect adequate capacity and services, including changes in MCO services, benefits, geographic service areas, payments or enrollment of a new population in the MCO.	This measure will be used to assess whether enrollees have reasonable access to Medicaid covered services. The MCO will be required to report changes in the provider network as they occur. Language in the Medicaid contract, (Addendum 1) specifies that the MCO must "submit notice within 10 days to the Department of any addition or deletion of subcontracts involving (i)a clinic or group of physicians, (ii)an individual physician, (iii)a mental health provider and/or clinic". If provider network capacity is not adequate, an

				enrollment cap may be implemented.
K. Ombudsman for Dane Co. SSI MC Program.	Janice Seiber, DHCF	Ombudsman perform the following functions: 1. Assist enrollees in getting the health care services they need by working with the MCO and the enrollee. 2. Work directly with enrollees and MCOs to get problems resolved without going through the formal, written grievance process. 3. Assist the enrollees with formal written grievances when necessary. 4. Assist enrollees in the fair hearing process when needed. Ombuds work with the internal advocates at the MCOs to investigate complaints and grievances and to assess whether providers or the MCOs are denying Medicaid covered services.	Daily	The State receives reports on grievances and analyzes the data for service specific trends in denials. If indicated, inappropriate denials could result in corrective action under the contract.
L. On-site review for Dane Co. SSI MC Program.	Jodie Mender, DHCF, Peg Algar, DHCF, Randy Zirk, DHCF, Joyce Allen, DDES	The MCO will be notified approximately 30 days prior to scheduled routine audits being conducted via letter from the Division of Health Care Financing. The Department will develop an annual schedule of known audits for the next contract period. Either a desk audit or an on-site audit will be done, depending on the issue(s) being investigated. As with the initial "Readiness Review" described earlier in this document, regular audits will review compliance with certification and contract requirements.	As needed.	Any areas of operation that appear to be out of compliance with the Medicaid contract will be outlined in a report to the MCO. The MCO will have a specified amount of time to correct the problem(s), and may be assessed penalty fines if the deadline for compliance is not met.
M. Clinical and non-clinical Performance Improvement Projects for Dane Co. SSI MC Program.	EQRO (MetaStar Inc.)	The MCO must monitor and evaluate the quality of care and services through performance improvement projects for at least two (2) areas annually. The MCO will be asked to submit one PIP, utilizing criteria outlined in the Medicaid contract or the optional BCAP Typology, during the first 12-18 months of the program, after there has been a sufficient length of enrollment and number of enrollees for the MCO to gain experience with the population and to collect adequate	Annually	These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustainable over time, in clinical care and/or non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

		data for analysis. Protocol 3: Validation of Performance Improvement Projects		Protocol 3: The protocol utilizes three activities in validating PIPs: 1) assessing the MCOs/PIHPs methodology for conducting the PIP, 2) verifying actual PIP study findings, and 3) evaluating overall validity and reliability of study results. Activity One, *Assessing the MCO's/PIHP's Methodology for Conducting the PIP,* involves ten steps: 1. Review the selected study topic(s). 2. Review the study question(s). 3. Review selected study indicator(s). 4. Review the identified study population. 5. Review sampling methods (if sampling was used). 6. Review the MCO's/PIHP's data collection procedures. 7. Assess the MCO's/PIHP's improvement strategies. 8. Review data analysis and interpretation of study results. 9. Assess the likelihood that reported 10. Improvement is "real" improvement. 11. Assess whether the MCO/PIHP has sustained its documented improvement.
N. Performance measures addressing quality of care for Dane Co. SSI MC Program	EQRO	Specified performance measures will be calculated by the department from encounter data which is routinely generated and reported as part of managed health care operations. Protocol 2 requires that the State specifies: ➢ The performance measures to be calculated by MCOs/PIHPs ➢ The specifications to be followed in calculating these measures; and ➢ The manner and mechanisms for reporting these measures to the State.	Encounter data will be reported quarterly and performance measures calculated at routine intervals which will vary depending on the type of information required to calculate the measure and the specified look-back period. See attached Quality Indicators document.	High priority areas for performance measurement were identified by stakeholders and the Department of Health and Family Services based on the identified programmatic goals for the SSI Managed Care Program. Performance measures were then developed that will be used to identify utilization patterns and initially, constitute the baseline data from which subsequent performance goals may be established. These measures are also intended to provide valuable information that will be used in conjunction with other available data and information to ensure that the MCO meets the

				standards set by the state for quality management and the achievement of desired outcomes. Protocol 2 activities address: 1. Review of the data management processes of the MCO/PIHP; 2. Evaluation of algorithmic compliance (the translation of captured data into actual statistics) with specification defined by the State; and 3. Verification of either the entire set or a sample of the State-specified performance measures to confirm that the reported results are based on accurate source information. Validation will be done by the EQRO to determine the extent to which the performance measures calculated by the MCO followed specifications established by the State for the calculation of the performance measure. The activity includes a review of the data management processes of the MCO (in addition to the validation of the data).
O. Periodic comparison of number and types of Medicaid providers before and after waiver for Dane Co. SSI MC Program.	Jodie Mender, DHCF Peg Algar, DHCF	The number and types of Medicaid providers will be evaluated prior to implementation, at each contract renewal, and during the contract period when there is a change in the network.	This comparison will be done at a minimum during each contract renewal period and when there is a change in the network and more often if network changes occur.	This information will help the Department determine whether the network is adequate to serve the population.
R. Test 24 hours/7 days a week PCP availability for	Jodie Mender, DHCF Peg Algar, DHCF	The MCO must demonstrate that medical care is available 24 hours a day, seven days a week at the readiness review and with each certification at the start of a new contract period. The Department approves the plan or provides	During certification and contract renewals.	The MCO must demonstrate that medical care is available 24 hours a day, seven days a week at the readiness review and with each certification at the start of a new contract period.

Dane Co. SSI MC program.		recommendations for changes to comply with this requirement.		The program must have one toll-free or local telephone number that enrollees or individuals acting on behalf of an enrollee can call at any time to obtain authorization for urgent care and to obtain authorization for transportation. This telephone number must provide access to individuals with authority to authorize treatment as appropriate. Responses to these calls must be provided within 30 minutes. If the MCO fails to respond timely, the MCO will be liable for the cost of subsequent care related to that illness or injury incident whether treatment is in or out-of-plan and whether the condition is emergency, urgent, or routine. The Department will have access to the weekly log of incoming calls to the 24-hour PCP access line and review it regularly.
S. Utilization review for Dane Co. SSI MC program.	EQRO (MetaStar Inc.), Peg Algar, DHCF	During MetaStar's implementation of Protocol 1 (Determining MCO/PIHP Compliance with Federal Medicaid Managed Care Regulations), information is obtained regarding how the entity is conducting its own utilization review activities and determine if they are monitoring for under-utilization or over-utilization of services.	Annually	Information is used to determine if the MCO is monitoring for under-utilization or over-utilization of services. If the MCO does not have a process in place to monitor utilization, they are informed that they need to develop and utilize such a process within a specified period of time, or will be considered out of compliance with the Medicaid contract.
T. Other	EQRO	Protocol 1: Determining MCO/PIHP Compliance with Federal Medicaid Managed Care Regulations.	Annually	Protocol 1: The protocol uses two main sources of information to determine compliance with the proposed BBA requirements: 1) document review and 2) interviews with MCO/PIHP personnel. The seven activities that comprise the core activities of the protocol include: 1. Planning for compliance monitoring activities. 2. Obtaining background information from the State Medicaid agency. 3. Document review.

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				4. Conducting interviews. 5. Collecting any other accessory information; e.g., from site visits. 6. Analyzing and compiling findings. 7. Reporting results to the State Medicaid Agency.